

Coding connections

Provider tips for accurate billing and coding

October 2026

Priority Health coding quick reference

Our top denial prevention tips for providers

#1. E/M + preventive visits

Bill only when documentation supports a significant, separately identifiable E/M service. **Remember:**

- Separate problem evaluated and managed
- Additional work beyond routine preventive care
- Documentation clearly distinguishes services

Example: Annual exam + Nevus with excision and sent for pathology

#2. Preventive colonoscopy coding

Avoid common errors:

- Medicare screening codes for commercial members
- Symptom diagnosis as primary when preventive
- Missing Modifier 33

Best practice:

- Report preventive diagnosis
- Append Modifier 33 when appropriate
- Verify Priority Health coding requirements

#3. Diagnosis pointers

Before submitting claims:

- Verify diagnosis-to-procedure linkage
- Ensure pointers accurately reflect services rendered

Incorrect pointers can trigger medical necessity denials.

#4. DME: Diabetic testing supplies (A4253, A4259)

Remember:

- No authorization required ≠ unlimited coverage
- Frequency limits still apply
- Remember date spans for claims
- Documentation requirements remain in effect

#5. Submit records up front

Attach when appropriate:

- Visit notes
- Operative reports
- Medical necessity documentation
- Supporting clinical records

Result: Faster review, fewer appeals, reduced repeat denials



Final claim checklist

- ☐ Documentation supports services billed
- ☐ All dates of service documented
- ☐ Diagnosis pointers verified
- ☐ Required modifiers applied
- ☐ Correct preventive coding used
- ☐ Medical necessity supported
- ☐ Records attached when needed
- ☐ Priority Health-specific coding verified



Denial prevention formula

Accurate documentation

+

Correct coding

+

Appropriate modifiers

=

Fewer denials